Supreme Court, U. S.
FILED
AUG 15 1979
MICHAEL RODAK, JR., CLERK

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1978

No. 78-1318

HELEN B. O'BANNON,
SECRETARY OF PUBLIC WELFARE, PENNSYLVANIA,
Petitioner,

v.

TOWN COURT NURSING CENTER, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

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INTEREST OF *AMICUS* NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

The National Citizens' Coalition for Nursing Home Reform is a national organization comprised of fifty-eight local community advocacy groups and many individuals who are actively involved in issues of nursing home reform and advocacy throughout the United States. Of

particular interest to the Coalition are questions concerning empowerment of nursing home residents, quality of life and care in nursing homes, and enforcement of federal and state nursing home regulations.

This case—the first Supreme Court consideration of nursing home residents' rights in any context—is of particular importance to Coalition members.

The Coalition appears as *amicus* in this case with the consent of all parties and respectfully urges this Court to affirm the decision of the Third Circuit below.

SUMMARY OF ARGUMENT

The Due Process Clause states that no person may be deprived of "life, liberty or property, without due process of law."

The Third Circuit ruled below *en banc*, *Town Court Nursing Center, Inc. v. Beal*, 586 F.2d 280 (3rd Cir. 1978), that nursing home residents are entitled to procedural due process when the facility in which they live is threatened with decertification from the Medical Assistance Program. The Court stated, in a companion case, *Klein v. Califano*, 586 F.2d 250, 258 (3rd Cir. 1978) (*en banc*):

> The essence of due process is that legally generated expectations of continued receipt of Government benefits may not be summarily denied by arbitrary administrative action. Notice and an opportunity to be heard enable the recipient of Government benefits to retain their benefits by proving to the administrative agency that specified reasons or causes for termination of benefits have not occurred.

The Third Circuit based its finding of due process rights on nursing home residents' property interest in continued

occupancy in their long-term care facility. Two provisions of the Medical Assistance statute and regulations were found to create the protected property claim. This ruling was a proper analysis of this Court's decisions and should be affirmed.

Several additional claims not addressed by the courts below give further support to the Third Circuit's conclusion that residents are entitled to procedural due process in the decertification proceeding.

In addition to statutory property interests in continued occupancy, nursing home residents enjoy property interests based on contract and on mutually explicit expectations.

Relocation to other facilities, made necessary by the decertification of a facility, creates great stress in elderly nursing home residents who select one facility as home and expect to remain there for the rest of their lives. The increased mortality and morbidity that result—identified as the phenomenon of transfer trauma—directly implicate the life interests of nursing home residents.

Liberty interests, as well, are affected by a decertification decision. A nursing home often becomes the entire world known by its residents. The relationships with other residents and staff and the familiar patterns of life that a known institution provides are permanently disrupted when decertification occurs. Liberty interests in contract, association, privacy, and health are irrevocably affected.

These interests also constitute the statutory benefit of nursing home care. Since these interests are diminished by involuntary transfer, decertification is a reduction in Medicaid benefits within the meaning of the Medical

Assistance law. Residents are thus entitled to the rights of prior notice and hearing provided by federal regulation.

These substantial interests of residents in continued occupancy in their homes cannot be adequately represented by the nursing home provider. Resident and provider interests in decertification will often diverge, particularly over issues of evidence and remedy.

Residents' interests can be protected only through a pre-decertification evidentiary hearing. No post-decertification administrative remedy is available for residents under the Medicaid law, nor could such a remedy, even if offered, be effective. Residents cannot be made whole for these deprivations as they can when the government benefit at stake is cash assistance. Once the status quo is disrupted, it cannot be recreated. In addition, residents can contribute substantially to the correctness of the administrative decision whether decertification is appropriate. This administrative decision is discretionary and based on a balancing of factors related to adequate resident care. Finally, the public interest is furthered by giving residents pre-decertification evidentiary hearings.

ARGUMENT

I.

NURSING HOME RESIDENTS ARE ENTITLED TO THE PROTECTIONS OF THE DUE PROCESS CLAUSE WHEN THE FACILITY IN WHICH THEY RESIDE IS THREATENED WITH DECERTIFICATION AS A MEDICAID PROVIDER.

A.

Nursing Home Residents Have a Life Interest in Continued Occupancy in the Nursing Home Where They Reside.

The interest in life is the first of three interests protected by the due process clause. *Roe v. Wade*, 410 U.S. 113, 157 (1973).

Decertification of nursing homes from participation in the Medicaid program may directly threaten the lives of nursing home residents.

1. *Nursing home residents are often physically, socially and economically dependent on the facilities where they reside.*

A nursing home is an institution where people in need of frequent nursing attention live for long periods of time. Most of the residents of nursing homes are elderly; the mean age of residents is 81.[1] The average length of stay is more than two years.[2]

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[1] National Center for Health Statistics: Charges for Care and Sources of Payment for Residents in Nursing Homes, United States, 1973-74 National Nursing Home Survey. *Vital and Health Statistics.* Series 13-No. 32. DHEW Pub. No. (PHS) 78-1883. Public Health Service. Washington, D.C., U.S. Government Printing Office, Nov., 1977, p. 2 [hereinafter CHARGES FOR CARE].

[2] SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMMITTEE ON AGING, NURSING HOME CARE IN THE

[footnote continued]

Many residents need direct assistance from facility staff in the activities of daily living: more than half need help in walking and bathing; nearly half need help in dressing; and more than one in ten needs help in eating.[3] Nursing home residents, on the average, have four or more chronic diseases[4] and take four to seven different drugs per day.[5]

While nursing home residents are physically dependent on facilities for assistance in life activities, they are also often isolated from contact with the community beyond the facility. More than half the nursing home residents have no close family ties or visits with friends, having outlived the friends and family they enjoyed when younger.[6] As a result, the only human and social contact many residents experience takes place solely within the facility with staff and other residents.

In addition to being physically and psychologically vulnerable, many nursing home residents are economically dependent as well. Nationally, more than half the country's 1.2 million nursing home residents use Medical Assistance as their primary source of payment for their care.[7] Many of these people did not begin their institutionalization as poor people. However, the cost of nursing home care is so high[8] that many residents exhaust their personal financial resources, become impoverished, and only then, turn to Medicaid for support.[9] Indeed,

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UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. Rep. No. 93-1420, 93d Cong., 2d Sess. (1974), p. — [hereinafter FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT].

[3] FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 17.

[4] FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 17.

[5] FAILURE IN PUBLIC POLICY, Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs and Kickbacks" (Jan. 1975), p. x.

[6] FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 16.

[7] In 1973-74, 48% of all nursing home residents relied on Medical Assistance. CHARGES FOR CARE, p. 11. This figure contrasts sharply with the 13% who used Medicaid as the primary source of payment in 1969. CHARGES FOR CARE, p. 23. Between 1964 and 1973-74, primary sources of payment for nursing home care were reversed. In 1964, 53% of all residents used private resources for primary payment and 47% of all residents relied on public sources of various types. By 1973-74, only 37% of all residents relied primarily on their own resources, while 60% of residents relied on public sources. CHARGES FOR CARE, pp. 22-23. The reversal is undoubtedly due, at least in part, to the tremendous increase in the cost of nursing home care. Between 1964 and 1973-74, the average monthly charge for nursing home care increased 159% from $183 to $459. CHARGES FOR CARE, p. 18. In constant dollars, discounting the effects of inflation, the average monthly resident charge increased 60% between those years. CHARGES FOR CARE, p. 20.

[8] By 1977, the average monthly cost for long-term care was $800. Moss, TOO OLD, TOO SICK, TOO BAD, 1977, p. 9. In 1975, the monthly charge for a bed in a skilled nursing facility often exceeded $1000. Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ.L.REV. 304, 306 (1975).

At the present time, charges for nursing home care are substantially greater. In New Jersey, for example, in litigation challenging a state regulation requiring facilities to provide care for Medical Assistance recipients as a condition of state licensure, nursing homes reported that their daily private rates varied between $49 and $63. These figures represent annual charges between $17,885 and $22,995. *New Jersey Association of Health Care Facilities v. Finley*, C.A. Nos. A-1950-77 through A-1954-77 and A-2207-77 (consolidated).

[9] Medicare, the health insurance program for elderly and disabled people, 42 U.S.C. §§ 1395 *et. seq.*, pays for very little nursing home care in the United States. As a program focused on acute care and catastrophic illness, Medicare has stringent limitations on coverage for long-term care: persons must need skilled nursing services and must enter a nursing home within fourteen days of hospitalization at least three days in length, due to the same "spell of illness." 42 U.S.C. §§ 1395d(a)(2), 1395f(a)(2)(C), 1395f(h).

[footnote continued]

nearly half the current Medicaid recipients entered their facilities as private pay residents and converted to Medical Assistance only after an impoverishing period of private-pay status.[10] There are at present between one-quarter and one-half million nursing home residents who were forced into poverty by paying for their necessary nursing home care.[11]

The physical, psychological and financial dependency that characterizes many members of the nursing home population makes the nursing home institution much more than simply the provider of certain nursing and medical services. Nursing homes become, in many instances, the entire and only worlds known by their

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The result of these statutory restrictions is that Medicare pays only 1% of the nation's nursing home bills. CHARGES FOR CARE, p. 12. Indeed, Medicare's share of nursing home costs is reduced from the 4% it paid in 1969. CHARGES FOR CARE, p. 23.

Elderly persons needing nursing home care must generally pay for the care themselves until they exhaust their personal resources and convert to Medical Assistance.

[10] Congressional Budget Office, LONG-TERM CARE FOR THE ELDERLY AND DISABLED (Budget Issue Paper) (Feb., 1977), p. 24 (". . . 47.5 percent of nursing home patients whose care are paid for by medicaid in 1974 were not initially poor by state definitions but depleted their resources and qualified as medically needy.").

[11] If there were a million persons in nursing homes, half were supported by Medicaid, and half of the Medicaid recipients entered their facilities as private-pay residents, the number of people impoverished by paying for their nursing home care would be 250,000. The number is undoubtedly larger, however, because of the greater number of people institutionalized in nursing homes and the substantial increases in nursing home charges over the past several years. If there are 1.2 million people in nursing homes and 65% are supported by Medicaid and 60% entered facilities as private-pay residents, the number forced into poverty by nursing home costs would be 468,000. The number, of course, may be far higher.

residents.[12] It is not surprising, then, that any disruption in the fragile environment can have a devastating impact on nursing home residents.

2. *Transfer trauma is a life threatening phenomenon which records greatly increased mortality and morbidity rates for involuntarily-transferred elderly nursing home residents.*

Studies of elderly nursing home residents involuntarily moved from one facility to another document greatly increased mortality and morbidity rates. The phenomenon at work is called "transfer trauma."

When elderly nursing home residents are forced to move from one nursing home to another, the result is often death. Lieberman, "Relocation Research and Social Policy," 14 THE GERONTOLOGIST 494, 495 (1974); Bourestom and Tars, "Alterations in Life Patterns Following Nursing Home Relocation," 14 THE GERONTOLOGIST 506, 508 (1974); Aldrich and Mendkoff, "Relocation of the Aged and Disabled: A Mortality Study," 11 JOURNAL OF AMERICAN GERIATRIC SOCIETY 185 (1963). Increased mortality rates of as much as 500% to 900% have been documented. Killian, "Effect of Geriatric Transfers on Mortality Rates," 15 SOCIAL WORK 19 (1970). The fatal consequences of involuntary transfer appear quickly, often within three to four months of relocation. Aldrich and Mendkoff, "Relocation of the Aged and Disabled: A Mortality Study," *supra*.

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[12] Nursing homes have been compared to migrant labor camps because of the substantial control they exercise over those under their care. Comment, *Nursing Home Access: Making the Patients Bill of Rights Work*, 54 J.URB.LAW 473, 497 (Winter, 1977). No similar analogy has ever been drawn for other health care providers.

Nursing home residents who do not die as a result of being moved from familiar surroundings and relationships frequently become depressed and disoriented and reduce their levels of activity. Bourestom and Tars, "Alterations in Life Patterns Following Nursing Home Relocation," *supra.* Passive behavior increases while involvement in meaningful activity decreases. Institute of Gerontology, University of Michigan-Wayne State University (Bourestom and Pastalan), "Relocation Report 2" 9 (1974). Psychological deterioration and serious physical illness may also become more pronounced. Miller and Lieberman, "The Relationship of Affect State and Adaptive Capacity to Reactions to Stress," 20 JOURNAL OF GERONTOLOGY 492, 494 (1965).

A recent review of relocation literature suggests the central role of the residents' perceived control or lack of control over transfer. Residents moved involuntarily without choice or control are more likely to be harmed by relocation than those who are allowed to exercise some degree of control. Schulz and Brenner, "Relocation of the Aged: A Review and Theoretical Analysis," 32 JOURNAL OF GERONTOLOGY 323, 332 (1977). The significance of psychological factors is highlighted by the finding that anticipation of relocation can have effects almost as severe as those caused by the transfer itself. Bourestom and Tars, "Alterations in Life Patterns Following Nursing Home Relocation," *supra.*

Finally, the degree of environmental change is a major factor in determining whether involuntary transfer is likely to increase mortality and morbidity. A moderate environmental change, requiring a move to a new facility but no change in staff and residents, is less life-threatening than a radical environmental change requiring new staff, new program of activities, new physical environment

and new resident population. Bourestom and Tars, "Alterations in Life Patterns Following Nursing Home Relocation," *supra.* Even relocation to a facility providing demonstrably better care and services than the former facility results in increased mortality and morbidity, a finding which underscores the dominant role of social and psychological factors in nursing home care. Aldrich and Mendhoff, "Relocation of the Aged and Disabled: A Mortality Study," *supra.*[13]

The pronounced and irreversible dangers of transfer trauma prompted the Administration on Aging in HEW to issue a Technical Assistance memorandum more than four years ago calling attention to the problem of involuntary relocation. The Memorandum (AoA-TA-75-1, February 19, 1975), advised:

> There is a genuine hazard in the relocation of infirm aging persons from one facility to another. Dramatic increases in mortality far in excess of what would normally be expected have been documented.

Federal district courts presented with evidence concerning transfer trauma have uniformly been persuaded both of its existence and of its importance to involuntary transfer determinations. The district court in *Bracco v. Lackner,* 462 F.Supp. 436, 453 (N.D. Ca. 1978), for example, observed:

> The Department's action presents the specter of precipitous and involuntary mass transfer of plaintiffs from the Center to numerous other facilities scattered throughout the Greater Bay Area. Many patients would be separated from friends,

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[13] See Appendix 2 of the Brief of *Amici Curiae* Jill Harris and the Residents of Edgefield Manor for a full discussion of relocation literature.

family, and their personal physicians. The trauma that such a dislocation would cause many if not all the plaintiffs is well-documented . . . . The damage to individuals in terms of physical and emotional deteriorations, and increased mortality incidence as a result of "transfer trauma" has been recognized by the federal courts . . . .

There is no doubt that the relocation of plaintiffs will work a grievous loss upon them. Aside from the physical and emotional danger presented by the "transfer trauma" syndrome, the evidence shows that the plaintiffs will suffer a serious disruption in their personal lives.

See also Hathaway v. Mathews, 546 F.2d 227, 231 (7th Cir. 1976); *Roberson v. Wood*, 464 F.Supp. 983 (E.D. Ill. 1979); *Burchette v. Dumpson*, 387 F.Supp. 812, 819 (E.D. N.Y. 1974).

B.

Nursing Home Residents Have Liberty Interests in Continued Occupancy in the Nursing Homes Where They Reside.

Nursing home residents enjoy liberty interests in continued occupancy in their nursing homes which are protected under procedural due process.

The involuntary transfer of nursing home residents resulting from decertification deprives residents of several liberty interests, which this Court has variously identified as privacy, association and health. Loss of home, separation from family and friends, and risk to health and safety all deprive residents of values which are "fundamental" and "implicit in the concept of ordered liberty." *Roe v. Wade, supra*, 410 U.S. at 152.

It would be difficult to contend that nursing home patients do not have a strong interest in avoiding unnecessary transfers. Many of them have been uprooted from the communities in which they spent their working lives. For most of these patients, the limited world of the nursing home is the only community in which they retain a stable network of personal and social relationships. In addition, invalids and prospective invalids alike have a strong interest in avoiding the unnecessary physical hardship that could result from a mistaken transfer. These "home" and "health" interests, I submit, are among those that most persons would regard as being encompassed by the protections of the due process clause.

Town Court Nursing Center, Inc. v. Beal, supra, 586 F.2d at 289 (Adams, J., concurring).

A nursing home is more than a mere collection of unrelated individuals. *Smith v. Organization of Foster Families*, 431 U.S. 816 (1977). It is a self-contained social structure and, for most residents, the exclusive and intimate environment where most of their personal and social relationships occur. Facility staff with whom residents relate on an intimate and daily basis often take the place of family and friends. These "emotional attachments that derive from the intimacy of daily association" are protected by the liberty interest in association. *Smith v. Organization of Foster Families, supra*, 431 U.S. at 844.

Relocation may also separate residents from ties with their community. For those residents with family and friends nearby, relocation to distant communities (an often unavoidable result of decertification) disrupts protected relationships and interferes with protected rights of association. *Moore v. City of East Cleveland*, 431 U.S. 494 (1977).

Family, friends, and community groups visiting nursing home residents often assume advocacy roles with respect to quality of care and life in the facility. Such protective and supportive relationships between disadvantaged persons and specially skilled advocates have long been accorded constitutionally-protected status by the court as a right of association. *In re Primus*, 436 U.S. 410 (1977); *United Mine Workers of America, District 12 v. Illinois State Bar Association*, 389 U.S. 217 (1967); *Brotherhood of Railroad Trainmen v. Virginia*, 377 U.S. 1 (1964); *NAACP v. Button*, 371 U.S. 415 (1962).

The stress of abrupt separation from family, friends, and community may have permanent and disastrous effects on residents' mental and physical well-being. Decisions carrying such a risk of physical harm or death to an individual lie within the protected physician-patient relationship and are protected from interference by the patients' right to privacy. *Doe v. Bolton*, 410 U.S. 179 (1973); *Roe v. Wade, supra*; *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

The liberty clause of the due process clause includes the right to contract as well. *Board of Regents v. Roth*, 408 U.S. 564, 572 (1972). Nursing home residents have two separate contract interests protected by the liberty clause.

Most residents of nursing homes have contracts with the facilities in which they live. Indeed, many states now require admission contracts as a matter of state law.[14] Such contracts typically define the rights and responsibilities of both parties and incorporate by reference the

[14]See, for example, Maryland, COMAR 10.07.02.08A and Michigan, Mich. Stat. Ann. § 21766.

applicable federal and state law. Residents' personal contract rights are liberty interests protected under the due process clause.

Nursing home residents' second contract claim arises from their status as third party beneficiaries of the Medicaid provider agreement between the state and each participating nursing home.[15] *Roberson v. Wood, supra*; *Berry v. First Healthcare Corp.*, CCH Medicare-Medicaid Guide ¶ 28,693 (D.N.H., Oct. 26, 1977); *Fuzie v. Manor Care, Inc.*, 461 F.Supp. 689 (N.D. Ohio 1977).

Moreover, almost all Medicaid beneficiaries also pay directly for a portion of their nursing home care.[16] Some "categorically needy" nursing home residents are required to apply their personal income to the cost of their institutional care as a condition of receiving Medicaid.[17]

[15]All Medicaid providers must have contracts called provider agreements with the single state agency charged with the administration of the Medicaid program in order to receive Medicaid reimbursement. 42 C.F.R. §§ 442.10–442.30.

[16]More than 96% of all nursing home residents in 1973–74 who used Medicaid as the primary source of payment for their nursing home care used their own income or family support as a secondary source. CHARGES FOR CARE, p. 17.

[17]Coverage under Medical Assistance is required by law for persons who are "categorically needy"—those who are eligible for certain cash assistance government benefit programs. 42 U.S.C. § 1396a(a)(10)(A). Optionally categorically needy persons are either those people who would not be eligible for cash assistance benefits if they were not institutionalized, 42 C.F.R. § 435.722, or those people who would be eligible for cash assistance benefits if they were not institutionalized, 42 C.F.R. § 435.211. *See generally* 42 C.F.R. §§ 435.700–435.734, describing requirements for applying categorically needy institutionalized recipients' income to cost of care.

In addition, states are given a further option to provide coverage for "medically needy" persons. Medically needy people are those whose income is too high to allow them to qualify for categorical assistance programs but who are otherwise eligible for Medical Assistance. 42 U.S.C. § 1396a(a)(10)(C), 42 C.F.R. § 435.4.

42 C.F.R. §§ 435.700, 435.725. Under these eligibility provisions, Medicaid nursing home residents typically are allowed to keep $25 per month for personal needs; the remainder of their income is applied to the cost of their nursing home care. 42 C.F.R. §§ 435.700-435.740. Eligibility provisions for persons qualifying for Medical Assistance as "medically needy" are similar. Again, such persons are required to apply their personal income to the cost of their institutional care. 42 C.F.R. §§ 435.813, 435.815. Aside from the $25 per month which medically needy recipients may keep for personal needs, all income, from whatever source, is applied to the cost of institutionalization. *Friedman v. Berger*, 547 F.2d 724 (2d Cir. 1976). For both categorically needy and medically needy Medicaid beneficiaries, Medical Assistance pays the difference between the resident's income and the facility's Medicaid rate.

C.

Nursing Home Residents Have a Property Interest in Continued Occupancy in the Nursing Home Where They Reside.

The Third Circuit in both decisions below rested its finding of due process rights on nursing home residents' property interest in continued occupancy in their long-term care facility. The court first looked to the Medicaid statute and regulations as the possible source of property entitlements. Two provisions were found to create a protected property interest in continued occupancy: the free-choice-of-provider provision, 42 U.S.C. § 1396a(a)(23), 42 C.F.R. § 431.51 [formerly 45 C.F.R. § 249.20]; and the section in the Patients' Bill of Rights prohibiting involuntary transfer of nursing home residents except for "medical reasons or for [their] welfare or that of other

patients, or for nonpayment for [their] stay," 42 C.F.R. § 442.311(c)(1)-(3) [formerly, 45 C.F.R. § 249.12(a)(1)(ii)(B)(4)]. These provisions, the Third Circuit reasoned, "create a legitimate entitlement to continued residency at the home of one's choice absent specific cause for transfer." 586 F.2d at 258.

While this decision was correct, two additional provisions of the Medical Assistance Program, as shown below, reinforce the court's conclusion that residents enjoy an entitlement to continued occupancy. Residents' property interests also derive from contract and from the "policies and practices" of the Medicaid program. *Perry v. Sindermann*, 408 U.S. 593 (1972).

One factor supporting a need for due process protection is the threatened loss of a benefit currently enjoyed. *Board of Regents v. Roth, supra*, 408 U.S. at 576. *Greenholtz v. Inmates of Nebraska Penal and Correctional Complex*, ___ U.S. ___, 99 S.Ct. 2100, 2105 (1979), reiterated the constitutional significance of the distinction between "'losing what one has and not getting what one wants.'"

Medicaid beneficiaries are not entitled to have their care paid for in an uncertified facility. As a result, residents whose facility may be decertified are threatened with being forced to move to a certified facility, if they want Medicaid to continue paying for their care.[18] Decertification necessarily requires the involuntary

[18] There is no real choice involved, since Medicaid beneficiaries are without the financial means to become private-pay residents at a decertified facility, even if they wanted to. Indeed, a facility which relies substantially on Medicaid for support of its residents may be forced to close, if decertified, forcing the involuntary transfer of Medicaid and private-pay residents alike.

transfer of Medicaid beneficiaries and demands that beneficiaries give up what they have: residence in a particular facility.

A second factor indicating the presence of protected property interests is the circumstances under which the particular benefit at issue can be terminated. If termination of the benefit is permissible only for cause, the beneficiary has protected property interests. *Arnett v. Kennedy*, 416 U.S. 134 (1974); *Perry v. Sindermann, supra.* If, however, the benefit can be terminated at will and without cause, no due process rights apply. *Bishop v. Wood*, 426 U.S. 341 (1976); *Board of Regents v. Roth, supra.* Most recently, the Court used this analysis of due process claims in *Memphis Light, Gas and Water Division v. Craft*, 436 U.S. 1 (1978), a case challenging the utility's termination of services without affording its customers procedural protections. The utility there argued that since it may discontinue service for nonpayment of proper charges, due process does not apply. This Court was unpersuaded, noting that customers have a property interest in continued utility service when state law permits termination of service only "for cause." The factual dispute as to whether a utility bill is correct in amount is sufficient to create a protected property interest in consumers currently receiving utility service.

> Although the customer's right to continued service is conditioned upon payment of the charges properly due, "'[t]he Fourteenth Amendment's protection of "property" . . . has never been interpreted to safeguard only the rights of undisputed ownership.' [citing *Fuentes*] Because petitioners may terminate service only 'for cause,' respondents assert a 'legitimate claim of entitlement' within the protection of the Due Process Clause.

436 U.S. at 11-12. Similarly, in this case, nursing homes' participation in Medicaid, like utilities' provision of service, can be terminated only "for cause." 42 C.F.R. § 442.12(d). Accordingly, nursing home residents, like utility customers, both the true beneficiaries of the service, have a protected property interest in ensuring that service is not terminated if proper "cause" for termination does not exist.

1. *Statutory entitlements to government benefits are property interests protected by procedural due process.*

The Due Process Clause of the Fifth Amendment protects interests in property which extend "well beyond actual ownership of real estate, chattels or money." *Board of Regents v. Roth, supra,* 408 U.S. at 572. This Court has long recognized that beneficiaries' interests in government entitlement programs—where statutory and administrative standards determine program eligibility—are protected by procedural due process. *Board of Regents v. Roth, supra,* 408 U.S. at 576; *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970).

In addition to the statutory provisions cited by the Third Circuit to support a protected property claim in continued occupancy, two other provisions create a statutory entitlement.

First, Medicaid law requires that the program be carried out in a manner ensuring the "best interests of the recipients." 42 U.S.C. § 1396a(a)(19). This provision requires that a state plan for medical assistance include:

> [S]uch safeguards as may be necessary to assure that eligibility for care and services under the plan

> will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of recipients.

See Coe v. Hooker, 406 F.Supp. 1072, 1081 (D.N.H. 1976); *American Medical Association v. Weinberger*, 395 F.Supp. 515 (N.D. Ill. 1975), *aff'd*, 522 F.2d 921 (7th Cir. 1975).

Second, nursing homes participating in the Medical Assistance Program can be decertified only for "good cause."

> If the medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement with a facility.

42 C.F.R. § 442.12(d). State agencies may not arbitrarily refuse or deny provider certification.

When Medicaid beneficiaries are guaranteed by law and regulation that they can choose to live at whatever certified nursing home they prefer; that they cannot be required to leave the nursing home except for certain specified reasons; that their facility will not be decertified except for "good cause"; and that the entire Medicaid program will be carried out in a manner ensuring their "best interests," they have a legitimate statutory expectation of continued occupancy in the nursing home where they live.[19]

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[19] *Moore v. Johnson*, 582 F.2d 1228 (9th Cir. 1978), cited with approval by both the State (20-21) and HEW (32-33), is simply not on point. *Moore* involved a challenge to the veterans' benefits statute, 38 U.S.C. §610, which authorizes the Administrator of the Veterans' Administration, in his discretion and "within the limits of the Veterans' Administration facilities" to "furnish . . . nursing home care which the Administrator determines is needed."

[footnote continued]

The State's and HEW's contention that no statutory property interest is at issue must fail because it misperceives the nature of the nursing home benefit.

a. The government benefit at issue in the nursing home context is continued residence at the particular nursing home where the resident lives.

Both the State and HEW argue that property interests are not at stake in this case because nursing home residents remain free to choose among qualified providers, whether or not the particular facility where they currently reside continues to participate in the Medical Assistance Program. (State 15; HEW 33.) This argument begs the question. Whether the particular facility where the resident lives satisfies Medicaid requirements is the issue to be determined in a decertification proceeding. Residents have a protected property interest in this

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No statutory entitlement to benefits is at stake. The VA law gives beneficiaries no choice of facility, no guarantee that they can be transferred only for good cause, no promise that facilities can be decertified only for cause and no requirement that the program be administered in recipients' "best interests"—all provisions of the Medicaid law here in issue. Whatever the merits of the *Moore* decision, it has no relevance to this case.

Caton Ridge Nursing Home, Inc. v. Califano, 447 F.Supp. 1222 (D. Md. 1978), *aff'd* No. 78-1290 (4th Cir., Feb. 26, 1979), CCH Medicare-Medicaid Guide ¶29,631, while on point, was wrongly decided. The decision is silent on issues of concern to residents, such as transfer trauma, disruption of residents' liberty interests in association, privacy and health, availability of alternative facilities, and quality of care. The absence of any discussion of these issues suggests that they may not have been raised. In *Caton Ridge*, residents were apparently represented jointly with the facility. The decision reinforces the Coalition's belief that residents' interests in decertification are not necessarily the same as the facility's interests. *See* pp. 28-34.

determination which is separate and distinct from their protected property interest in their own continued eligibility for benefits. *Klein v. Califano, supra,* 586 F.2d at 260 n. 16.

Residence at a nursing home as a Medicaid beneficiary bears little factual resemblance to receiving monetary aid under a cash assistance program. In a cash assistance program such as AFDC, the beneficiary is concerned with the dollar value of the benefits awarded, but has little interest in the actual form such benefits take. Whether the grant is paid in cash or through check is largely irrelevant to the cash assistance beneficiary; money is fungible.

The same cannot be said of the Medicaid nursing home benefit. The nursing home resident generally has no interest in the cost of the nursing home benefit paid by Medicaid, but substantial interest in the particular facility where the benefit is provided.

Medicaid reimbursement for nursing home services may vary dramatically between facilities in a single state, depending upon the reasonable cost-related formula which the state has chosen to adopt.[20] Two facilities providing the same level of care[21] may be reimbursed

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[20] Since 1976, HEW has required that nursing homes be reimbursed on a reasonable cost-related basis. 42 U.S.C. § 1396a(a)(13)(E). Within federally established guidelines, states are free to set their own reimbursement formulas. States may group providers into classes or may set rates on an individual facility basis. *See generally* 42 C.F.R. §§ 447.272-474.311, and 43 F.R. 4861, 4863 (Feb. 6, 1978).

[21] Level of care is a term of art in the Medicare and Medicaid programs relating generally to the intensity of services required by a nursing home resident. *Feld v. Berger,* 424 F.Supp. 1356, 1358 (S.D.N.Y. 1976).

at substantially different rates. For the nursing home Medicaid resident, however, the issue of reimbursement is largely irrelevant. The Medicaid beneficiary is generally required to contribute to the cost of his nursing home care by paying to the state all of his income except a $25 monthly personal needs allowance which he is permitted to retain. 42 C.F.R. §§ 435.700, 435.725, 435.813, 435.815. The state, through Medicaid, pays the difference between the beneficiary's personal contributions and the nursing home's state-determined Medicaid rate. Cost-of-living increases in government pensions, Social Security benefits, Railroad Retirement benefits or any other payments contributed by the beneficiary for his care are automatically given to the State, whose own portion of the nursing home rate is reduced accordingly. It is apparent that if a Medicaid nursing home beneficiary is transferred from a nursing home charging Medicaid $600 per month to a facility charging $700 per month, that $100 per month increase in cost holds little interest to the resident. His personal share in the costs remains constant. (*See* pp. 15-16.)

In sharp contrast to the resident's general lack of concern with Medicaid's reimbursement rate for his facility is his substantial concern with the particular facility where the care is provided. As demonstrated above (pp. 5-9), the nursing home becomes the actual and permanent home for its residents and the social environment where virtually all the residents' relationships and experiences occur. To alter this environment by moving the resident to another facility is to change in drastic and fundamental ways the nature of the benefit provided.

2. *Nursing home residents' contractual rights to continued occupancy in their nursing homes are property interests protected by procedural due process.*

As discussed above (pp. 14-16), nursing home residents have contract claims in the nursing home context, both as direct contractors for services and as third party beneficiaries of provider agreements between the states and facilities.

These contract claims are property interests protected under the due process clause. *Board of Regents v. Roth, supra*; *Perry v. Sindermann, supra.*

3. *Nursing home residents' reasonable and mutual expectations of continued occupancy in their nursing homes are property interests protected by procedural due process.*

"Policies and practices" not specifically rooted in either statute or contract may also give rise to property interests protected by procedural due process. *Perry v. Sindermann, supra,* 408 U.S. at 603. The relevant question is whether a "system in practice" creates an unwritten "common law" of nursing homes that residents will remain institutionalized without transfer. *Perry v. Sindermann, supra,* 408 U.S. at 602. Mutually explicit understandings, in the nature of an implied contract, create protected property interests. *Perry v. Sindermann, supra. See also Leis v. Flynt,* ___ U.S. ___, 99 S.Ct. 698 (1979).

There can be no dispute that elderly persons entering nursing homes generally expect to remain institutionalized for the rest of their lives. Few residents return to

the community to live once they enter long-term care facilities.

For Medicaid beneficiaries, the possibility of returning home is even more remote than for private-pay residents. Medicaid beneficiaries, almost by definition, have limited or no income or financial resources which would enable them to re-establish the homes or apartments they left to enter their nursing homes. Indeed, many residents sell their personal residences and deplete their assets paying for their nursing home care and turn to Medical Assistance only after their financial resources of a lifetime are exhausted. (*See* pp. 6-8.)

Residents' reasonable expectations that they will remain in the long-term care facility they have chosen are not unilateral. They are strongly reinforced and made explicitly mutual by state and federal practices. States and HEW rarely decertify long-term care facilities from participation in the Medicaid and Medicare programs, despite pervasive deficiencies.[22] The more common practice is requiring plans of correction. 42 C.F.R. § 442.251(b).

In 1974, for example, the Senate Special Committee on Aging reported that out of 7000 Medicaid skilled nursing homes, 4776 facilities with deficiencies were certified with six-month timetables for correction, while only 327 facilities were decertified by the states.[23] The

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[22] Regan, *When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate,* 65 GEO.L.J. 691, 693-4 (1977); Comment, *Regulation of Nursing Homes—Adequate Protection for the Nation's Elderly?* 8 ST. MARY'S L.J. 309, 320 (1976); Regan, *Quality Assurance Systems in Nursing Homes,* 53 J.URB.L. 153, 180-85 (1975).

[23] FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 104.

federal record with respect to Medicare is no different. In 1971, HEW stated that the agency had decertified only about 100 Medicare skilled nursing facilities—a mere 1.5% of the total.[24] The rare enforcement activities that result in decertification establish a nursing home system "in practice" which only rarely requires the transfer of residents and which creates expectations in residents that they will be able to remain in the facilities they choose.[25]

II.

THE INVOLUNTARY TRANSFER INEVITABLY RESULTING FROM DECERTIFICATION OF A NURSING HOME CONSTITUTES A REDUCTION IN MEDICAID BENEFITS WHICH ENTITLES RESIDENTS TO NOTICE AND HEARING RIGHTS PROVIDED UNDER FEDERAL REGULATION.

As demonstrated above (pp. 21-23), the government benefit at issue in the nursing home context is continued residence at a particular facility. In light of the phenomenon of transfer trauma and the irrevocable destruction of associational, health and contractual interests which

[24] FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 104.

[25] Decertification is a grossly inadequate enforcement device. The sanction has such significant implications for residents and facilities that it is infrequently used. State agencies are understandably hesitant to use the drastic sanction, fully aware that the Medicaid bed shortage may mean there is no place to move residents whose facility is closed. The result is that many facilities continue operating with serious deficiencies. A variety of more flexible enforcement mechanisms such as citation systems and receiverships (*see* n.31 at pp. 31-2) would more likely succeed in bringing about the goals of regulation: higher quality of care and life residents. *See* Brown, *An Appraisal of the Nursing Home Enforcement Process, supra.*

involuntary transfer causes, any change in residence is a clear factual reduction in benefits which entitles beneficiaries to the administrative rights to timely notice and opportunity for hearing. 45 C.F.R. § 205.10(a)(5). *Bracco v. Lackner, supra,* 462 F.Supp. at 453. The district court in *Klein v. Mathews* aptly described how involuntary transfer results in reduction of benefits in fact:

> . . . to cause the recipient to suffer the grievous loss attendant to transfer is to reduce the benefits to which the recipient would otherwise be entitled. The involuntary transfer of Medicaid patients is simply not a cost free decision. While it may be argued that a mere change in the form of delivery of governmental benefits may not work a reduction, e.g., payment of benefits by check or by cash, it would be a callous disregard of the real life consequences to say that a Medicaid patient who suffers transfer trauma is receiving the same benefits under Title XIX as a patient not forced to similarly suffer. While cash and checks may be functional equivalents, the benefits available to involuntarily transferred patients and those not transferred are not. The trauma associated with transfer and the losses suffered as a result of transfer are tantamount to a reduction of benefits. Such reduction triggers procedural due process protections.

430 F.Supp. 1005, 1010 (D.N.J. 1977). Changing the form of the Medicaid nursing home benefit changes the benefit itself. There can be no question Medicaid nursing home benefits are reduced if transfer occurs. Under these circumstances, federal regulations require notice

and an opportunity to be heard before benefits may be reduced.[26] 45 C.F.R. § 205.10(a)(5).

III.

NURSING HOMES CANNOT REASONABLY BE EXPECTED TO RAISE ALL ISSUES OF CONCERN TO RESIDENTS IN A DECERTIFICATION PROCEEDING.

Both the State and HEW argue that nursing homes can reasonably be expected to raise all issues that might have a bearing on the decertification proceeding. The State contends, "[I]t is entirely reasonable to assume that the operator of the nursing home will bring all the relevant information to bear on the question [of decertification] in order to protect his investment." (State 19.) HEW concurs in this view. (HEW 40.) These arguments ignore the realities of the Medicaid nursing home program.

[26] Indeed decertification of a facility may actually result in "discontinuance or termination" of Medical Assistance if alternative Medicaid beds are not found for the residents who must be moved. *Bracco v. Lackner, supra,* 462 F.Supp. at 444. The common discrimination against Medicaid recipients and the general unavailability of Medicaid placements make this possibility a serious concern. Decertification of deficient facilities may in fact be delayed because of the lack of sufficient alternative placements. *Klein v. Califano, supra,* 586 F.2d at 253. Certainly if facilities are decertified and Medicaid beds are not provided to displaced residents, the result is the discontinuance or termination of Medical Assistance to Medicaid beneficiaries. Federal regulations, under such circumstances, require prior notice and hearing. 45 C.F.R. § 205.10(a)(5).

A.

Nursing Homes May Choose Not To Oppose Their Decertification from the Medicaid Program.

The State's and HEW's contention is based on the assumption that nursing homes will oppose their decertification from the Medical Assistance program in all instances where residents would similarly oppose decertification. Such is not the case.

The decision to participate in the Medical Assistance program in the first instance or to contest a decertification effort by the state or HEW rests solely with the facility.[27] Given the proprietary status of the nursing home industry in the United States,[28] the decision is often a financial one. It must be noted that Medicaid generally reimburses providers at a lower rate than private-pay residents pay (and, by law, Medicaid cannot pay a higher rate).[29] Facilities, as a result, often see a financial benefit in discriminating against Medicaid

[27] Participation in the Medicaid program is the voluntary decision of providers. *Briarcliff Haven, Inc. Department of Human Resources of the State of Georgia,* 403 F.Supp. 1355, 1364 (N.D. Ga. 1975) (". . . Briarcliff is not required to participate in the Georgia Medicaid program, such a decision is completely voluntary on the part of the provider. If Briarcliff does elect to participate in the program it may terminate participation at any time and for any reason.")

[28] More than three-quarters of the country's 23,000 facilities, containing more than two-thirds of the country's nursing home beds, are operated on a for-profit basis. FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, p. 22.

[29] The upper limit for Medicaid reimbursement to skilled nursing and intermediate care facilities is "the provider's customary charge." 42 C.F.R. § 447.315(a). States may reimburse facilities at a lower rate. *Briarcliff Haven, Inc., supra,* 403 F.Supp. at 1362.

beneficiaries. Indeed facilities frequently participate in the Medicaid program when they first open for business—in order to establish a reputation in the community and to develop a good cash flow with guaranteed Medicaid income—only to withdraw from participation when financial considerations change. *Roberson v. Wood, supra*; *Stitt v. Manor Care, Inc.*, CCH Medicare-Medicaid Guide ¶ 29,409 (N.D. Ohio, Oct. 24, 1978). Other facilities which have few Medicaid-supported residents or which rely on Medicaid for only a small portion of their income may voluntarily decide to withdraw from program participation or not actively to resist decertification.

The all-too-common discrimination against Medicaid beneficiaries that pervades much of the nursing home industry[30] belies the State's and HEW's claim that nursing homes threatened with decertification will necessarily oppose decertification vigorously.

B.

The Interests of Nursing Home Residents and Nursing Home Facilities Are Not Necessarily Synonymous.

Even if nursing homes faced with decertification from Medicaid forcefully contest their decertification, the interests of residents and facilities in such circumstances will not necessarily be synonymous. As demonstrated above (pp. 29-30), facilities may be reluctant to present certain types of evidence—for example, on the issue of

[30] *See*, for example, *Pennsylvania Nursing Home Ombudsman Project Final Report: The Pennsylvania Experience* (January, 1979); Ohio General Assembly Nursing Home Commission, *A Program in Crisis* (Interim Report, June, 1978), p. 8.

transfer trauma—because of concern that such evidence will return to haunt them if they later attempt to discharge a particular resident. Crucial evidence relevant to resident concerns may simply not be placed before the administrative agency.

On issues of remedy, residents' and facilities' interests may most clearly diverge. Residents may want to argue that a plan of correction should be required to remedy a defect, 42 C.F.R. §§ 442.101(d)(2), 442.105(b), 442.202(c), 442.253(a), while facilities may prefer to urge waiver of the requirement altogether, 42 C.F.R. §§ 442.101(d)(1), 442.202(c), 442.253(a). Or residents may want to suggest to the state enforcement agency that it use a remedy other than decertification to correct a problem and affirmatively bring the facility into compliance. For example, under the recently enacted Michigan nursing home reform law, Public Law 493 (Dec. 6, 1978), the state may issue citations for civil penalties or place a deficient facility in receivership if the facility fails to comply with nursing home laws.[31] Deficient facilities

[31] Nursing home citation and civil penalty systems have been enacted in Alaska (Alaska Stat. §§ 8.70.160 and 8.70.170); California (Health and Safety Code §§ 1417-1431) (West); Connecticut (Conn. Gen. Stat. §§ 19-607-613, 19-620); Florida (Fla. Stat. § 400.12); Iowa (Iowa Code 135C.36-135C.48); Kansas (Kan. Stat. § 39-923 (Supp. 1977)); Kentucky (Ky. Rev. Stat. § 338.991); Michigan (Mich. Comp. Laws § 217998); Minnesota (Minn. Stat. § 144A.10); New Jersey (N.J. Rev. Stat. §§ 26: 2H-13-26:2H-16); North Dakota (N.D. Cent. Code § 23-16-06); Oregon (Or. Rev. Stat. §§ 441.705-441.745); Washington (Senate Bills Nos. 2337, 2338); West Virginia (W.Va. Code §§ 16-5C-5, 16-5C-10); Wisconsin (Wis. Stat. §§ 50.04(4), (5)).

Nursing home receivership laws have been enacted in Connecticut (Conn. Gen. Stat. Ann. § 19-621a (1979) (West)); Kansas (Kans. Sess. Laws, Ch. 162); Michigan (Mich. Stat. Ann. § 16614 (13) (Supp. 1979) (West); Minnesota (Minn. Stat. Ann. § 144A.15

[footnote continued]

would be unlikely to suggest to the state agency that it use such alternative enforcement mechanisms. Finally, nursing home residents may agree with the state agency that closing a facility is appropriate and necessary, and may want to appear solely for purposes of ensuring that the resulting transfers are carefully and properly carried out. Again, facilities could be expected to have little interest in this issue of vital concern to residents.

In short, the interests of residents and facilities are not in all instances the same. Residents cannot reasonably be expected to rely on facilities to present their interests fully and forcefully.

Indeed, in this case, the district court ordered separate counsel for the residents when Town Court's attorneys filed suit and sought to represent both the facility and the residents.

This Court, too, has been sensitive to the unique interests of persons that make their independent representation essential. *Trbovich v. United Mine Workers of America*, 404 U.S. 528 (1972), involved the right of union members to intervene in a lawsuit filed by the Secretary of Labor to set aside an election of union officers for violation of the Labor-Management Reporting and Disclosure Act. LMRDA makes civil suits by the Secretary the exclusive post-election remedy for violations of Title IV of the Act. 29 U.S.C. § 483. Union members whose complaint to the Secretary initiated the enforcement procedure that led to the lawsuit sought to intervene in the Secretary's case, pursuant to Rule 24(a)

(Supp. 1979) (West)); Missouri (Senate Bills Nos. 328, 432, 35 and 419 (passed May, 1979)); New Jersey (N.J. Rev. Stat. §§26: 2H-37 *et seq.*) (Supp. 1978); New York (N.Y. Public Health Law, Art. 28-A, 2862); Wisconsin (Wis. Stat. Ann. § 50.05) (West).

Fed. R. Civ. P. This Court held that union members have that right, firmly rejected the Secretary's assertion that he adequately represented the union members' interests. Although the Secretary of Labor becomes the union members' "lawyer" for purposes of enforcing rights against the union in any action to set aside a union election, the Court recognized that members may "have a valid complaint about the performance" of their "lawyer." And at the remedy stage of such enforcement litigation, the Court observed, intervenors may properly assist the Court in devising a suitable order. 404 U.S. at 537 n. 8.

The right of nursing home residents to independent representation is even more pronounced. Certainly the facility's attorneys are not by law representing the interests of residents, as the Secretary of Labor represents union members in an election case. Moreover, residents, like union members, may file the initial complaints with the state agency that lead to the enforcement (i.e., decertification) proceeding. To exclude residents from the enforcement activity that follows their complaints deprives them of the opportunity to propose appropriate corrective action.

The need for genuinely independent counsel for nursing home residents cannot be denied.

C.

Residents' Legitimate Concerns in the Decertification Proceeding Are Their Own Interests and Not the Vicarious Assertion of Nursing Homes' Interests.

One of HEW's persistent themes in its brief is that decertification affects nursing home residents only tangentially and that the real interests at issue are those of long-term care providers. (HEW 29-32.) HEW flatly asserts that residents are trying vicariously to assert the rights of nursing homes by claiming procedural rights in decertification proceedings. This contention is without merit and mischaracterizes the Medicaid program.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, was enacted by Congress in 1965 in order "to enable each state to furnish medical assistance to aged and disabled persons whose income and resources are insufficient to meet the necessary costs of necessary medical services." *Bracco v. Lackner, supra,* 462 F.Supp. at 451. *See also Yanez v. Jones,* 361 F.Supp. 701 (D. Utah 1973).

Beneficiaries are not superfluous to the Medicaid program; they are the sole reason for its enactment and continued existence. The financial benefits received by providers for participating in Medicaid, while substantial, do not convert Medicaid into a program whose purpose is serving providers. It is the recipients of medical care and services who are the third party beneficiaries of the Medicaid program. *Roberson v. Wood, supra*; *Berry v. First Healthcare Corp., supra*; *Fuzie v. Manor Care, Inc., supra.*

Residents' interests in the decertification of their facilities are significant personal concerns.

IV.

ONLY A PRE-DECERTIFICATION EVIDENTIARY HEARING CAN ADEQUATELY PROTECT THE DUE-PROCESS INTERESTS OF NURSING HOME RESIDENTS.[32]

Before a person can be constitutionally deprived of an interest protected by the due process clause, some form of hearing is required. *Mathews v. Eldridge,* 424 U.S. 319, 333 (1976). The specific form such hearing must take depends upon analysis of the private and public interests at stake. This court in *Eldridge* identified three distinct factors that determine the nature of the required hearing. Each factor supports the nursing home residents' claim that only a pre-decertification evidentiary hearing can adequately protect their significant due process interests.

A.

Nursing Home Residents' Interests in Continued Occupancy Are Fundamental Human Rights.

The first factor in the equation is "the private interest that will be affected by the official action." *Mathews v. Eldridge, supra,* 424 U.S. at 335. As demonstrated,

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[32] Since the Court below remanded the case for a determination of the procedures necessary to satisfy the due process interests of nursing home residents, 586 F.2d at 283, the type of due process hearing which nursing home residents may be entitled to in a decertification proceeding is not actually before the Court in this case. However, both the state and HEW raised the issue in their briefs and the Court below alluded to the issue in the companion case, *Klein v. Califano, supra,* 586 F.2d at 261 and n.19. *Amicus* therefore addresses this issue briefly here, urging a finding that only a pre-decertification evidentiary hearing like that approved in *Goldberg v. Kelly, supra,* can satisfy the due process interests of nursing home residents.

nursing home residents' interests in continued occupancy in their homes touch upon the most fundamental of human rights.

Most basic of all is the right to life itself. Decertification of a long-term care facility necessarily demands the transfer of its Medicaid beneficiaries. That transfer may be life-threatening. Transfer trauma places residents' lives at direct and substantial risks and severely undermines their health.

Involuntary transfer of residents from a decertified facility also disrupts the fragile network of relationships that form within facilities between residents and staff. Liberty interests in association and privacy are damaged.

Finally, residents' statutory, contractual and mutually expectational property interests in remaining in their chosen homes are destroyed by decertification.

Deprivations of these dimensions cannot be cured by later administrative action. No post-termination remedy can restore life or recreate human relationships that are severed. *Contrast Mathews v. Eldridge, supra,* 424 U.S. at 340. Indeed, there is no post-decertification administrative remedy that residents can even invoke under the Medicaid law. *Klein v. Mathews, supra,* 430 F.Supp. at 1007. Thus, deprivations of these fundamental human rights become permanent, complete, and irrevocable. *Compare Goldberg v. Kelly,* 397 U.S. 254 (1970).

B.

Nursing Home Residents Can Contribute Substantially to the Questions at Issue in a Decertification Proceeding and Thereby Increase the Correctness and Reliability of the Administrative Decision.

Nursing home residents can contribute substantially to the resolution of issues presented in a decertification proceeding. Their full and active participation can help assure that the administrative decision is correctly made.

First, nursing home residents can secure expert testimony on technical questions at issue in decertification. On issues where technical expertise is required, there is no reason why nursing homes alone are capable of presenting that testimony. Residents, through counsel, can similarly contract with experts to testify on technical matters. Residents have done so. *Bracco v. Lackner, supra.*

Moreover, certain issues that are relevant to a decertification proceeding may not be adequately explored unless raised by the residents themselves. Prominent among these issues is transfer trauma. (*See* pp. 9-12.) Facilities may not want to stress too forcefully the adverse consequences of involuntary transfer because of their own frequent interest in transferring particular residents. When facilities discriminate against Medicaid recipients, for example, and demand the removal of a resident who has exhausted his personal financial resources, they may prefer not to be reminded that in another context—when they were faced with decertification—they argued that involuntary transfer is harmful.

There can simply be no question that the administrative determination to certify or not to certify a particular facility is a discretionary decision, based on the careful

balancing of factors related to adequate resident care. Indeed, the state agency is explicitly given authority to certify a facility with deficiencies if the deficiencies "do not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care." 42 C.F.R. § 442.105(a). (*See generally* 42 C.F.R. § 442.105, "Certification with deficiencies: General provisions.") The discretionary nature of the administrative decision makes plain that the state agency must decide whether the decertification of a deficient facility is less or more harmful for the facility's residents than certification. Only a full exploration of the residents' varied interests, presented from the residents' point of view, can help the state agency properly reach its determination about residents' "best interests." As demonstrated, the facility is not likely to present these questions adequately.

The second area where residents can substantially contribute to the reliability and correctness of the administrative decision is through direct testimony on quality of care and quality of life issues. Whether a facility with deficiencies can continue to provide adequate resident care is the issue to be decided by the state agency in the decertification proceeding. Residents can contribute relevant evidence on this issue, either personally or through family, friends and other advocates. Certainly residents who have first-hand experience with the facility's daily functioning are in an obvious position to testify about conditions and the care given. As the district judge observed in *Klein v. Mathews, supra,* 430 F.Supp. at 1011.

> While the court is deferential to the expertise of HEW, it is rank paternalism to suggest that patients who live in a facility, who have firsthand knowledge of the conditions, who are best equipped to describe how the facility has served them, cannot contribute to the process by which it is determined whether the facility meets federal standards. The court finds it hard to understand how HEW can seriously argue that the very patients whom HEW seeks to protect can have no purposeful role with respect to the condition of their environment.

See also Bracco v. Lackner, supra.

Finally, the mere fact of participation in the decertification decision-making process can have a substantially positive effect on residents' health and well-being. Social science research has documented that loss of control over their environment contributes to nursing home residents' psychological and physical deterioration. Mercer and Kane, "Hopelessness and Helplessness Among the Institutionalized Aged: An Experiment," 4 *Health and Social Work* 91 (Feb., 1979). An affirmation that residents can contribute in a meaningful way to decisions about their lives and environment will ensure that the Medicaid program is carried out in a manner promoting beneficiaries' health, welfare and "best interests."

Existing decertification procedures call on residents in only limited and inconsequential ways, if at all (HEW 37). The procedures fail to ensure full exploration of all relevant factors in the decertification determination, including use of alternative remedies not requiring transfer. The correctness of the administrative decision would be substantially enhanced by the participation of residents and their advocates.

C.

The Public Interest Is Furthered by Giving Nursing Home Residents a Pre-decertification Evidentiary Hearing.

The final factor to be balanced is the Government's interest, including the fiscal and administrative burdens which additional procedures would require. *Mathews v. Eldridge, supra,* 424 U.S. at 335, 347.

There can be no question that involvement of residents in decertification determinations would create little administrative burden, in light of the comparatively few facilities nationwide which are faced with formal decertification.[33] *See* pp. 25-26.

[33]Both the State and HEW suggest that a decision by this Court granting nursing home residents the procedural rights sought in this lawsuit would open the floodgates to unlimited litigation asserting procedural claims. The state speculates that Medicaid beneficiaries would seek hearings on whether physicians could be excluded from the Medicaid program. (State 15, 18.) HEW raises the specter of employees of government contractors asserting procedural rights when their employers' contracts are cancelled or not renewed (HEW 30).

As shown above (pp. 5-9), nursing homes are qualitatively different from other Medicaid providers. They are substitute homes for their residents, providing for the residents' medical, social, psychological, and spiritual needs on a long-term, permanent basis. A physician who provides even long-term medical attention is simply not in a position at all comparable to a total care community.

HEW's fearful analogy to government contractors is even less on point. The Medicaid program, as discussed above (p. 34), was enacted for the sole Congressional purpose of providing medical and health care for poor people. Government defense contracts, in contrast, while undeniably providing employment for individuals, have as their purpose the production of equipment necessary to the national defense. Any benefits to the contractors' employees are incidental to the contracts' primary purposes; such employees are certainly not the intended or third-party beneficiaries of the contracts.

HEW's intention to explore increased resident participation in decertification and termination proceedings (HEW 17, 37) recognizes the importance of resident involvement in these determinations and belies any assertion that such involvement is administratively burdensome. Indeed, the State of Maryland at the present time gives residents explicit notice of decertification determinations and advises them of their rights of appeal.

Finally, the Government, and the public at large, have a substantial interest in ensuring that government benefit programs are not implemented in a manner that is harmful to beneficiaries. *Goldberg v. Kelly, supra,* 397 U.S. at 264-5. The orderly operation of government programs is a fundamental concern to the public and program beneficiaries alike. Ensuring that decertification decisions are based on a careful balancing of all relevant factors, with affected persons guaranteed the right to be heard, is in the public interest.

CONCLUSION

For all of the reasons outlined above, *amicus* urges affirmance of the decision of the Third Circuit Court of Appeals.

Respectfully submitted,

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August 15, 1979